# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

★ 09942 Reg. Dist. No. 100

**1. PLACE OF DEATH:**

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Physicians Memorial Hosp.

How long in hospital or institution? 4 hrs. 15 min.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Lela Turner Bailey

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 17, 1873

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 5 | 25 | ..... hrs. ..... min. |

9. Birthplace: Bryantown, Chas., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER

12. Name: Thomas Turner

13. Birthplace: Wicomico, Md.

MOTHER

14. Maiden name: Lela McPherson

15. Birthplace: Bryantown Md.

16. Informant: Mr. Carlyle Turner

Address: Paper Creek, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 10-14-46 (month) (day) (year)

Cemetery or crematory: Trinity

Location: Wicomico, Md.

18. Funeral director: Hewitt & Ryon

Address: Waldorf, Md.

19. 10-13 1946 (Date rec'd by registrar) Julia H. Posey Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11, 1946 at 6:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937, to Oct. 11, 1946

and that I last saw h.. on alive on Oct. 11, 1946

| | DURATION |
|---|---|
| Immediate cause of death: Coronary thrombosis | 12 hrs |
| Due to: Coronary artery disease | Symptomatic 2 or 3 weeks |
| Due to: Essential hypertension | 20 yrs. |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did Injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury ..... Injured at work?

23. SIGNATURE: Jas. L. MacKenzie, M.D. M. D. or other

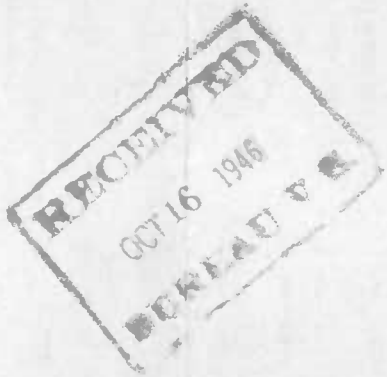
Address: La Plata, Md. Date signed 10-11-46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-46 5M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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09943

Reg. Dist. No. 105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

**1. PLACE OF DEATH:**

County: Charles

City or town: Pomfret

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Pomfret

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Tom Brown

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Negro | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) —

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 80-90 | | | ...hrs. ...min. |

9. Birthplace: Chas Co Md

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace

MOTHER

14. Maiden name: Emily Brown

15. Birthplace: Chas Co Md

16. Informant: Frank Wood

Address: Pomfret Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-17-46 (month) (day) (year)

Cemetery or crematory: St Joseph

Location: Pomfret MD

18. Funeral director: Hault & Ryon

Address: Waldorf MD

19. 10-16 1946 (Date rec'd by registrar) J. M. L. Moore Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14, 1946, at 3:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~on~~

Oct. 14, 1946, to 19...

and that I ~~last~~ saw h~~im~~ ~~alive~~ on Oct. 14 1946

| Immediate cause of death | DURATION |
|---|---|
| Probably, cerebral hemorrhage | Minutes |
| Due to: Generalized arteriosclerosis | 10 yrs. |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Deputy Medical Examiner
John E. MacKenzie, M.D.
M. D. or other

Address: La Plata, Md Date signed 10-14-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (179-E)

## CERTIFICATE OF DEATH

★ 09944 (05)

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.4 3M

**1. PLACE OF DEATH:**

County Charles

City or town White Plains
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:
—

How long in hospital or Institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County Charles

City or town White Plains
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war World War II

**3. (a) FULL NAME** Dwight Gilbert Collins

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 31-21

**8. AGE:** Years 25 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace White Plains md
(Town, county, and state)

10. Usual occupation Naval pd Factory Jefferson Hook md

11. Industry or business

FATHER 12. Name Horace L Collins

13. Birthplace Delaware

MOTHER 14. Maiden name Lillian Jones

15. Birthplace Philadelphia P.A.

16. Interment Paul Collins

Address Waldorf md

17. Burial Date thereof 10-10-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Mem

Location Arlington Va

18. Funeral director Hunt & Ryon

Address Waldorf md

19. 10-9 1946 M. L. Mooney
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1946, at 9:00-12:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on Oct. 7, 1946, ~~to~~ —, 19..

and ~~that I last saw him alive~~ on Oct. 7, 1946

| Immediate cause of death | DURATION |
|---|---|
| Barbiturate poisoning | 9-12 hrs. |
| Due to accident (presumably) | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10-6-46

Where did injury occur? White Plains (City or town) Charles (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Took overdose of sleeping capsules Injured at work? No

23. SIGNATURE James L. MacKavanagh M.D. Deputy Medical Examiner
M. D. or other

Address La Plata, Md. Date signed 10-7-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

# CERTIFICATE OF DEATH

09945

Reg. Dist. No. 100

**1. PLACE OF DEATH:**

County: Charles

City or town: Waldorf
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Woodland Acres

Stay in hospital or inst. (yrs., or mos., or days): 9-10 yrs.

Stay in this community (yrs., or mos., or days): 9-10 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Waldorf Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Woodland Acres
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Augusta Herring Danielson

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife: Frederick J. Danielson

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): August 5, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 2 | 8 | ____ hrs. ____ min. |

9. Birthplace: Gothenburg, Sweden
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER — 12. Name: ~~Carl Magnus Herring~~ Johannes Johannesson

FATHER — 13. Birthplace: Sweden

MOTHER — 14. Maiden name: Anna Mae Herring

MOTHER — 15. Birthplace: Sweden

16. Informant: Mrs. Hilda Lennis (daughter)

Address: Waldorf

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-16-46 (month) (day) (year)

Cemetery or crematory: Arlington Natl

Location: Arlington, Va.

18. Funeral director: W. W. Chambers Co.

Address: Washington D.C.

19. 10-13-46 19____ Julia H. Casey
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 13, 1946, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 6, 1946, to Oct. 13, 1946, and that I last saw h[illegible] alive on Oct. 6, 1946.

| | DURATION |
|---|---|
| Immediate cause of death: Auricular fibrillation & pulmonary edema | 7-8 hrs. |
| Due to: Hypertensive heart disease | 3 yrs. |
| Due to: Chronic glomerulonephritis | 10 yrs. |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ____ Injured at work?

23. SIGNATURE: Jas. L. Mackenzie Jr. M.D. M. D. or other

Address: La Plata, Md. Date signed 10-13-46

M

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

## CERTIFICATE OF DEATH

★ 9946 101
Reg. Dist. No.

1. PLACE OF DEATH:
County Charles
City or town Bryans Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles
City or town Bryans Road, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bernard W. Downs.

3.(b) Social Security Number

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6.(b) Name of husband or wife Edith H. Downs
6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Sept 19 1877

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 1 | 2 | hrs. min. |

9. Birthplace S. B. Prince Georges Co. Md.
(Town, county, and state)
10. Usual occupation Painter (Retired)
11. Industry or business
FATHER 12. Name George W. Downs.
13. Birthplace Maryland
MOTHER 14. Maiden name Laura Ann Talley
15. Birthplace Maryland
16. Informant Mrs. Edith Downs.
Address Bryans Road Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 23 46 (month) (day) (year)
Cemetery or crematory Shiloh.
Location Bryans Road.
18. Funeral director Hunt & Ryon
Address Waldorf Md
19. Oct. 24 1946 (Date rec'd by registrar) Mary Smithland Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1946 at 8 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1946, to 19
and that I last saw him alive on Oct 21 1946,

| Immediate cause of death | DURATION |
|---|---|
| Anemia & Cardiac Failure. | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo. C. Bickell M.D.
M. D. or other
Address Maryland Md Date signed Oct 24 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (956)

## CERTIFICATE OF DEATH

Reg. Dist. No. 5100

**1. PLACE OF DEATH:**

County: Charles

City or town: Hughesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Hughesville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** James Francis Farmer

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Negro | Married |

6.(b) Name of husband or wife: Florence Farmer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 17, 1889

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 57 | 5 | 28 | ...hrs. ...min. |

9. Birthplace: Charles County, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Edd Farmer
13. Birthplace: Charles County, Md.

MOTHER — 14. Maiden name: Ellen Briscoe
15. Birthplace: Charles County, Md.

16. Informant: Ellen Farmer
Address: Hughesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-17-46 (month) (day) (year)

Cemetery or crematory: St. Mary's
Location: Bryantown, Md.

18. Funeral director: Elmer M. Quade
Address: Hughesville, Md.

19. 10-16-46 (Date rec'd by registrar) 19.....

Julia H. Posey
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15 19 46 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 19 46, to Oct 15 19 46
and that I last saw h[illegible] alive on Oct 15 19 46

| Immediate cause of death | DURATION |
|---|---|
| Myocardial Failure | 1 hour. |
| Due to Rheumatic Cardio-Vascular Disease. | |
| Due to | |
| Other conditions Bronchial Asthma | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis C. Garesi M.D.
M. D. or other

Address: Hughesville, Md. Date signed: 10-16-46

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-46M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md-a)

# CERTIFICATE OF DEATH

# ★ 09948

Reg. Dist. No. 105

**1. PLACE OF DEATH:**
County: Chas
City or town: Waldorf Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Chas
City or town: Waldorf
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Charles Hagans

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | Col | |

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 26 1946

**8. AGE:** Years | Months | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Waldorf Md
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: William Hagen
13. Birthplace: Waldorf Md

MOTHER
14. Maiden name: Esther Hebard
15. Birthplace: Hill Top Md

16. Informant: William Hagen
Address: Waldorf Md

17. Burial, cremation, or removal (Which?) Burial Date thereof 10-28-46 (month) (day) (year)
Cemetery or crematory: St Peters
Location: Waldorf Md

18. Funeral director: Smith & Ogle
Address: Waldorf Md

19. 10/28/46 (Date rec'd by registrar) M. L. Monroe Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/27/46 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/27/46 to 19..... 19.....
and that I last saw h.. alive on 10/27/46

| Immediate cause of death | DURATION |
|---|---|
| Asphyxia | |
| Due to: Neoplasm | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: C. Wroten, M.D. M. D. or other
Address: Waldorf Date signed 10/28/46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

Form V. S. No. 5—50M—7-8-24

MARYLAND

# CERTIFICATE OF DEATH

COMMONWEALTH OF ~~PENNSYLVANIA~~
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

09949

1. PLACE OF DEATH
County of CHARLES — Registration District No. 2
Township of
or Borough of
or City of BENEDICT (No. ; St., Ward)
File No.
Primary Registration District No.
Registered No. 105
[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

2. FULL NAME MARY ANN BURRIS HOWARD

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| F | W | MARRIED |

5a. If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of EDWARD ERNEST HOWARD

6. DATE OF BIRTH (month, day, and year) JUNE 13, 1875

| 7. AGE | Years | Months | Days | IF LESS than 1 day ....hrs. or ....min. |
|---|---|---|---|---|
| | 71 | 3 | 27 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) CONCORD
(State or country) MARYLAND

PARENTS

10. NAME OF FATHER JOHN G BURRIS

11. BIRTHPLACE OF FATHER (city or town)
(State or country) MARYLAND

12. MAIDEN NAME OF MOTHER M. E. Garrett

13. BIRTHPLACE OF MOTHER (city or town)
(State or country) MARYLAND

14. Informant Louis Howard Gibson
(Address) Benedict Md.

15. Filed Oct 10, 1946 M L Mouzon
REGISTRAR

11—3184

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH OCTOBER (Month) 9 (Day) 1946 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1946, to Oct 9, 1946
that I last saw her alive on Oct 7, 1946
and that death occurred, on the date stated above, at 7 A. m.
The CAUSE OF DEATH* was as follows:

Cardiovascular decease
Hypertensive cardiac
Debilitation
(duration) 6 yrs. ? mos. ? ds.

CONTRIBUTORY (SECONDARY) Coronary thrombosis
(duration) 3-4 yrs. — mos. — ds.

18. Where was disease contracted, if not at place of death? Not contracted
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Alfred L. Lapen, M. D.
Oct 9 1946 (Address) Aquasco, Md.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL: Bryantown Cemetery
DATE OF BURIAL: Oct 11 1946

20. UNDERTAKER: Frank Joy Co.
ADDRESS: Wash 11 D.C.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (h) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (h) *Grocery*, (a) *Foreman*, (h) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer, Farm laborer, Laborer—Coal mine etc.* Women at home who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife. Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever write *None*.

Statement of cause of death.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term of the same diseases. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup") *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis* of *lungs, meninges, peritonaeum*, etc., *carcinoma, Sarcoma, etc.*, of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitia lnephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example. *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symtomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure." "Haemorrhage," "Inanition," "Marasmus," Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always quality as "PUERPERAL *septichaemia*" "PUERPERAL *peritionitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—Probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."

**Space for additional information by physician**

Evidence for the change of age is shown on

FILM No. I 08 OCT 24 1946

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09950

Reg. Dist. No. 104

**1. PLACE OF DEATH:**
County: Charles
City or town: Issue
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Issue
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Mary A. Martin

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | married |

6.(b) Name of husband or wife: W. N. Martin
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): 11 - 6 - 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 67 | 11 | 23 | hrs. min. |

9. Birthplace: Newport, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Robert L. Clements
13. Birthplace: Hughesville

MOTHER
14. Maiden name: Florence E. Thomas
15. Birthplace: Newport

16. Informant: W. N. Martin
Address: Issue

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 10-16-46 (month) (day) (year)
Cemetery or crematory: St. Mary's (Newport)
Location: Newport Md.
18. Funeral director: Hamilton Bryan
Address: Waldorf, Md.

19. 10-15 1946 William J. Frere
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 13 - 1946 at 11 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, c 1946 to Oct. 13, c 1946
and that I last saw her alive on Oct 13 - 1946

Immediate cause of death: Cerebral Hemorrhage

| | DURATION |
|---|---|
| Due to: | |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: T. K. Hayden M. D. or other
Address: Waynesboro Date signed 10-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

## CERTIFICATE OF DEATH

★ 09951

Reg. Dist. No. 101

**1. PLACE OF DEATH:**
County: Caroline
City or town: Welcome
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Welcome
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME:** George O. Mattingley

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Widowed |

6.(b) Name of husband or wife: Lillian Mattingly
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 6 1858

8. AGE: Years: 88 | Months: 4 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Hill Top Dor Co. Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: John Mattingley
FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Welch
MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Earnest Wedding
Address: Welcome, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 24 46 (month) (day) (year)
Cemetery or crematory: St. Ignatius
Location: Hill Top Md

18. Funeral director: Hunter & Ryon
Address: Waldorf Md

19. Oct 22 1946 (Date rec'd by registrar) Mary Swetland Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 1946 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 15 1946 to Oct 21 1946 and that I last saw h[illegible] alive on Oct 18 1946

| Immediate cause of death | DURATION |
|---|---|
| Uremia | |
| Due to: Chr. Cardio-renal disease | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Bicknell M.D.
M. D. or other
Address: Marbury Md Date signed: Oct 22 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (35a)

## CERTIFICATE OF DEATH

09952

Reg. Dist. No. 103

**1. PLACE OF DEATH**

County: Charles

City or town: Cobb Island

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mon.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Charles Co.

City or town: Bel Alton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Viola Leona Thompson

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | W |

6.(b) Name of husband or wife: Joseph Thompson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7-8-86

8. AGE: Years: 60 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Newport Charles Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Marlow

13. Birthplace: Newport Md

MOTHER — 14. Maiden name: Agnes Walther

15. Birthplace: Newport Md.

16. Informant: Leona M. Shymanske

Address: Cobb Island, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 12, 1946. (month) (day) (year)

Cemetery or crematory: St. Ignatius

Location: Chapel Point, Md

18. Funeral director: Joseph C. Mattingly

Address: Leonardtown, Md

19. Oct. 9 1946 (Date rec'd by registrar) Mary E. Burch Registrar

**MEDICAL CERTIFICATION** 46

20. DATE OF DEATH: 10 - 9 19~~48~~ at 2 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-4 19 40, to 10-9 19 46 and that I last saw h~~er~~ alive on 9-22-46 19

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | 10-5-46 |
| Due to: Hypertension | 6-4-40 |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D., or other

Address: La Plata, Md Date signed 10-9-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for the change of date of birth is shown on FILM No. I 08 OCT 30 1946

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (648)

## CERTIFICATE OF DEATH

★ 09953

Reg. Dist. No. 105

**1. PLACE OF DEATH:**
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** James Worthington Willett

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

B.(b) Name of husband or wife: Jessie Adams Willett
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): June 15, 1942 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 4 | 4 | ....hrs. ....min. |

9. Birthplace: Charles County, Md.
(Town, county, and state)
10. Usual occupation: Chautter
11. Industry or business: U.S. Naval Powder Factory
FATHER 12. Name: Walter Willett
FATHER 13. Birthplace: Chas. Co. Md.
MOTHER 14. Maiden name: Nothaum
MOTHER 15. Birthplace:
16. Informant: Mrs. Jessie Willett
Address: Indian Head. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22 1946 (month) (day) (year)
Cemetery or crematory: Piney Church Cemetery
Location: Waldorf. Md.
18. Funeral director: Hunt & Ryon
Address: Waldorf Md
19. Oct-22 1946 M. P. Sanders (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: October 19 1946 at 3:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h....alive on ....19....

| Immediate cause of death | DURATION |
|---|---|
| Strangulation | |
| Due to: Hanging (Suicide) | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 10-19-46
Where did injury occur? Indian Head (City or town) Chas (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Hanging Injured at work? No.

23. SIGNATURE: Frank Swann M.D. (M. D. or other)
Address: Indian Head Date signed: 10/21/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# STATE OF MARYLAND—CERTIFICATE OF DEATH

09954

**1. PLACE OF DEATH**

County Charles — Registration Dist. No. 101

Village or City Bryans Road — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

**2. FULL NAME** Edward Wright — If U. S. Veteran, specify WAR ____

(a) Residence: No. ____ St., ____ Ward. ____

(Usual place of abode) — If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| M | White | Widowed |

5a. If married, widowad, or divorced HUSBAND of (or) WIFE of Sally Atwell

6. DATE OF BIRTH (month, day, and yaar) Feb. 10, 1885.

| 7. AGE | Yaars | Months | Days | If LESS than 1 day, ____ hrs. or ____ min. |
|---|---|---|---|---|
| | 61 | 8 | 15 | |

OCCUPATION

8. Trade, profassion, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer

9. Industry or business in which work wes done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date daceased last worked at this occupation (month end year) ____ — 11. Total time (yaars) spent in this occupation ____

12. BIRTHPLACE (city or town) (State or country) Nanjimar, Charles Co., Maryland.

FATHER

13. NAME Ferdinand Wright.

14. BIRTHPLACE (city or town) (State or country) Charles Co. Md.

MOTHER

15. MAIDEN NAME Margaret Ann Wright

16. BIRTHPLACE (city or town) (State or country) Charles Co. Md.

17. INFORMANT Hallett Wright (Address) Nanjemoy, Md.

18. BURIAL, CREMATION, OR REMOVAL Placa Nanjemoy Md Date Oct 28, 1946

19. UNDERTAKER Hunt & Ryon (Address) Waldorf Md

20. FILED Oct. 25, 1946 Mary Smallwood Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** Oct (Month) 25 (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1946 to Oct 25, 1946

I last saw h[illegible] aliva on Oct 25, 1946; death is said to hava occurred on the date stated above, at 8 a. m.

The **PRINCIPAL CAUSE OF DEATH** and ralated causes of importance were as follows:

| | Date of onset |
|---|---|
| Chr. Cardiac Disease. | |
| | |
| | |
| | |
| | |

Other **Contributory Causes** of importanca:

Nama of oparation ____ Date of ____

What test confirmed diagnosis? ____ Was thara an autopsy? ____

23. If daath was due to axternal causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Spacify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Mannar of injury ____

Nature of injury ____

24. Was disaasa or injury in any way related to occupation of daceased? ____

If so, specify ____

(Signed) George C. Bickmore M. D.

(Address) Marbury, Md.

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

**ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN**